Healthpoint

Information from the Massachusetts Rate Setting Commission

Massachusetts
Rate Setting Commission

Two Boylston Street
Boston, MA 02116
(617) 451-5330

Barbara Erban Weinstein
Chairman
Louis I. Freedman
Commissioner
Margaret Long Randle
Commissioner

Vol. 1 No. 1 March 1996

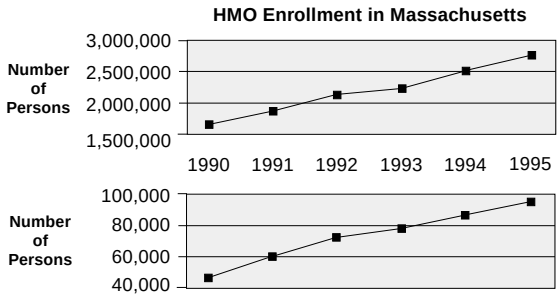
What is *Healthpoint*?

This is the first edition of a new quarterly publication combining the data and analytic resources of the Massachusetts Rate Setting Commission. Each *Healthpoint* will update trends of general interest and present a treatment of a health policy issue of current importance to policy makers in the Commonwealth. We would like to know what you would like to know. Please send your comments and suggestions for future policy topics to the Rate Setting Commission's Office of Communications: (617) 451-5310 (voice) or (617) 451-1878 (fax).

MASSACHUSETTS SENIORS BEGIN TO CHOOSE MANAGED CARE

Managed care is a familiar concept; today it is taken for granted as a viable option for providing quality, comprehensive care in a cost-effective manner for working-age people and their dependents. Now, the managed care market for seniors is heating up. Several managed care companies in eastern and central Massachusetts have joined Fallon Community Health Plan, with its long-standing service to seniors, in competing for Medicare beneficiaries.

Massachusetts is one of the leading states in this growing area of health coverage. Ninety-seven thousand (12 percent) of the Commonwealth's Medicare beneficiaries were enrolled in Health Maintenance Organizations (HMOs) as of December 1995, which is double the level five years earlier. This publication discusses some reasons for the rapid increase and identifies a number of policy issues.



Medicare is the nation's health insurance program for 37 million aged and disabled persons. Medicare covers hospital, physician and other acute care services. Total federal outlays are projected to be $181 billion in fiscal year 1995. Part A is the hospital insurance portion and requires no premium. Part B, which is optional, covers home health care and 80 percent of the cost (after a $100 deductible) of physician and other services for a monthly premium of $46.10. Parts A and B both require deductibles and copayments.

The rapid expansion of managed care in Medicare coincides with the national policy debate over the future direction of the Medicare Program. HMOs are developing products and entering the market in response to the likelihood that Medicare may soon be transformed into a program that provides its beneficiaries many choices of how to receive and finance care, from comprehensive managed care to catastrophic coverage coupled with a medical savings account. At the same time, in an effort to control Medicare costs, the Health Care Financing Administration (HCFA) has sought to enroll Medicare beneficiaries in HMOs and other types of managed care plans.

A majority of HMOs have "risk contracts." For each enrollee, HCFA pays the HMO a fixed monthly payment equal to 95 percent of the average Medicare fee-for-service (FFS) cost per capita in the enrollee's county. The HMO must provide, at a minimum, all services a Medicare beneficiary would receive while in the FFS system.

The Growing Popularity of Medicare HMOs

Managed care plans for the elderly have been available since 1985. Fallon Community Health Plan in the Worcester area was one of the first HMOs to offer coverage. Seniors were often reluctant to join because of an unwillingness to give up long-standing relationships with their doctors. These concerns have not disappeared. What has changed recently to boost HMO enrollment among seniors are, first, the increasing attractiveness of managed care; second, encroaching financial concerns of seniors; and third, the fact that HMOs are now marketing directly to seniors in an effort to expand market share.

Medicare HMO Contracts as of December 1995

	US	Mass.
Number of Plans	293	13*
Persons Enrolled in HMOs (1,000s)	3,809	97
Total Medicare Enrollment (1,000s)	37,000	843

*Blue Cross Blue Shield of Mass. launched a new poduct in January

Attractiveness. Primary care physicians have been contracting with HMOs in increasing numbers. As this happens, the option to join an HMO becomes more attractive to the physicians' elderly patients. Also, physicians can highlight for their patients the advantages of a managed approach to health care: more integrated care for those who need it most, primary and preventive services, and the removal of some barriers to care that exist in the fragmented FFS Medicare system.

Financial. In addition to Medicare Part A and Part B, many seniors purchase private supplemental insurance known as Medigap to cover the service gaps of existing fee-for-service coverage, such as prescription drugs, copayments and additional hospital care. Of the 843,000 Medicare beneficiaries in Massachusetts, approximately 300,000 purchase Medigap insurance, at an average annual cost of $2,000. Even with Medigap, many beneficiaries have high out-of-pocket costs, including coinsurance, deductibles, and a Part B premium of $46.10 per month. HMOs, on the other hand, offer a benefit package comparable to Medicare, plus additional benefits such as prescription drugs, vision and dental care not offered by traditional Medicare, with costs ranging from no additional premium (for most plans with no drug benefit) to $111 per month, with most plans requiring no deductibles or coinsurance. The national average Medicare HMO premium is $21 per month. A December 1995 study from the Massachusetts Office of Consumer Affairs reports that seniors who switch to a Medicare HMO can save up to 75 percent of their current total health expenditures. If current Medicare reform proposals include increased out-of-pocket costs for FFS beneficiaries, the financial advantage of HMOs would be enhanced.

Marketing. Some critics suggest that HMOs are able to provide comprehensive benefits at low costs because HMOs target younger, healthier seniors who require less care. They claim HMOs, though legally required to enroll all applicants who are eligible for Medicare Part A and Part B (except for those beneficiaries with end-stage renal disease and hospice patients), have in practice been marketing to a younger and healthier group of seniors. A General Accounting Office (GAO) report in November 1995 suggests that care for these seniors costs much less than the average Medi-

care beneficiary in FFS, a gap which has generated profits for the industry. HCFA requires that if revenues exceed a plan's cost by more than a specified allowance, plans are required to refund the savings either by increasing benefits or reducing premiums. There is little indication of the extent to which this rule has been enforced.

Policy Issues

Nearly 100,000, or 12 percent, of seniors in Massachusetts receive their medical care through HMOs, with numbers growing by 3,000 to 4,000 a month. (HMO enrollment of the entire Massachusetts population now exceeds 40 percent.) The Medicare beneficiaries remaining in traditional FFS represent a substantial potential market for managed care plans trying to expand. As the market continues to grow, state policy makers should understand how managed care might succeed or fail to meet the health needs of the elderly. A starting point may be to consider the following policy questions.

Will favorable selection occur and what will be the impact on costs? HMOs may recruit healthier Medicare beneficiaries, leaving a sicker and more costly group in the FFS sector.This could increase average FFS costs and subsequently Medigap insurance premiums, restricting access for those left in the FFS sector unable to afford the increases. A GAO report and a study by the Prospective Payment Review Commission support the hypothesis that the current reimbursement methodology overestimates the actual costs of HMO enrollees had they remained in FFS. An internal Congressional Budget Office memorandum concludes that, because of favorable selection, "Medicare's costs are likely to increase for each fee-for-service enrollee who switches to an HMO."

How will Medicaid expenditures be affected? HMOs may also save money by relying more heavily on nursing homes and home health care rather than hospital stays. Medicare only pays in part for the first 100 days of institutional skilled nursing care. Medicaid, funded jointly by the state and federal governments, is the safety net for long-term care for the 65-plus population: nearly three-quarters of Massachusetts nursing home residents receive assistance from Medicaid. There is some concern that a financial incentive exists for HMOs to admit costly Medicare beneficiaries to nursing facilities, where Medicaid will soon cover the costs of care.

What quality and satisfaction of care issues are there? Of particular interest is how well managed care is designed to meet the needs of the elderly who frequently have chronic, multiple conditions requiring different types of care from the under 65 population. Several studies show no negative effects on quality of care so far, and Medicare beneficiaries are generally satisfied with the care they receive. Nonetheless, there is currently a lack of benchmarks against which to measure quality; research to develop such benchmarks must catch up with the rapidly growing market before a thorough evaluation is possible.

What is the impact on service access? There is concern that access may be compromised to cut costs. Access may be inadequate for sicker beneficiaries, or for those in rural areas since managed care has mainly flourished in eastern and central Massachusetts, where capitation rates are higher. Access may also be restricted by HMOs limiting referrals to costly services and complex treatments.

What consumer protection issues should be considered? Beneficiaries have increasingly been asked to make choices, but the information needed to help make those choices has not kept pace. Currently, 13 plans offer managed care products for seniors in Massachusetts. The lack of information comparing HMO plans affects the ability of consumers to assess alternatives regarding differences in cost, benefits, copayments and deductibles.

What is the implication of upcoming federal changes? A number of policy discussions concerning Medicare HMOs are underway in Washington. There is a proposal to mitigate some of the regional variation in the reimbursement formula by sending more money to low-cost plans in the South and West and less to high-cost urban areas such as Boston. Second, Medicare officials are considering lowering by two percentage points an increase in HMO capitation payments that they proposed last October. Since many plans began marketing Medicare products based on an expectation of the higher increase, there is the potential that they will be unable to provide the level of benefits they are currently marketing. Questions may arise about how to protect the benefits of those already enrolled, regardless of what payment increase is finally approved. Lastly, there is concern that a Medicare reform plan may not provide sufficient funds to monitor the program to determine if quality and access standards are being met.

The enrollment of seniors in managed care is likely to continue in Massachusetts. The Massachusetts Division of Medical Assistance hopes to enroll beneficiaries eligible for both Medicare and Medicaid into managed care in the near future. As the numbers increase, current issues will continue to exist while others develop. Monitoring and evaluating the plans over time will determine how managed care can be a cost-efficient, high quality option for the health care needs of the elderly.

Further Reading

U.S. Government Publications

Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem. General Accounting Office, November 1995 (GAO/HEHS-96-21)
Medicare: Increased HMO Oversight Could Improve Quality and Access to Care. General Accounting Office, August 1995 (GAO/HEHS-95-155)
Medicare Risk HMOs: Beneficiary Enrollment and Service Access Problems. Office of the Inspector General, April 1995 (OEI-06-91-00731)

Other Sources

Michael J. Langan and Joseph J. Martingale, "Medicare Risk-Based HMOs: The Growing Market and Implications for Employers" Benefits Law Journal Vol. 8, No. 3 (Autumn 1995)
Harold S. Luft, ed., HMOs and the Elderly. (Ann Arbor: Health Administration Press, 1994)

Did you know?

Hospital Facts

	Massachusetts FY95 Data Submitted to Date	Massachusetts Comparable FY94 Data	Massachusetts FY94	Massachusetts FY93	Massachusetts FY90	U.S. FY93	California FY93
Number of Hospitals							
Acute	83	87	87	89	92	5,261	429
Non-Acute	53	54	54	54	65	862	64
Number of Acute Hospital Discharges (thousands)	730	760	823	881	895	30,748	3,052
Number of Acute Hospital Discharges/1,000 population	***	***	137	147	153	118	95
Number of Acute Hospital Days/1,000 population	***	***	766	873	1,046	831	542
Acute Hospital Length of Stay	5.39	5.64	5.68	5.97	6.82	7.02	5.69
Percent Inpatient Hospital Revenues	N/A	N/A	64%	67%	72%	73%	75%
Percent Outpatient Hospital Revenues	N/A	N/A	36%	33%	28%	27%	25%

Nursing Home Facts

	Massachusetts FY94	Massachusetts FY93	Massachusetts FY92	Massachusetts FY91	U.S. FY93	New York FY93
Number of Total Facilities	566	568	563	567	16,959	646
Number of Facilities with Medicaid Contracts	518	514	529	521	***	***
Number of Resident Days/population	2.97	2.93	3.06	3.03	2.31	2.11
Median Occupancy Rate	95.2	96.1	96.3	96.6	95	12.9%
Operating Expenses per Resident Day	$118.09	$108.27	$103.36	$99.82	$72.11	$132.45
Net Patient Revenue per Resident Day	$118.88	$110.65	$105.23	$100.28	$73.50	$133.28

Sources: Massachusetts Rate Setting Commission (MRSC); *Hospital Statistics - 1994/95* (American Hospital Association); The Guide to the Nursing Home Industry - 1991, 1993, 1994, 1995 (HCIA, Inc.and Arthur Anderson LLP); *Variations and Trends in Licensed Nursing Home Capacity in the States*, R. Dunah, Jr. et al. (October 1993).

Staff for this publication:

Kara Curtis
Harry Lohr
Diane McKenzie.
Carrie Norbin
Robert Seifert
Ron Villanueva-Autry